DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Weisman

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **01-021**

2. STATE: Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

OCT - 9 2001

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT: (P+I)
a. FFY 2001 $ ~~132,270,000~~ 949,500
b. FFY 2002 $ 5~~34,144,250~~ 1,306,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D
Part I
Pages 1 through ~~19~~ 20 (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D
Part I
Pages 1 through 18

10. SUBJECT OF AMENDMENT:

Nursing Facility Medicaid Payment Rates

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Cy B Bumberfor

13. TYPED NAME:
DENNIS BRADDOCK

14. TITLE:
Secretary

15. DATE SUBMITTED:
9/28/01

16. RETURN TO:
Department of Social and Health Services
Medical Assistance Administration
623 8th St SE MS: 45500
Olympia, WA 98504-5500

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
OCT - 9 2001

18. DATE APPROVED:
JUN 27 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 1 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME:
Bonnie Butterfield

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

POSTMARK: 10/8 (DATE) @ Oly (CITY/STATE)

P+I charges authorized by the State on 6/14/02 & 6/21/02.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Washington
NURSING FACILITIES AND SWING BED HOSPITALS

Effective July 1, 2001, and July 1, 2002

Section I. Introduction:

This State Plan Amendment (SPA) to Attachment 4.19-D, Part I, describes the overall payment methodology for nursing facility services provided to Medicaid recipients: (1) by privately-operated nursing facilities, both non-profit and for-profit; (2) by nursing facilities serving veterans of military service operated by the State of Washington Department of Veterans Affairs; and (3) by nursing facilities operated by public hospital districts in the state. Both privately-operated and veterans' nursing facilities share the same methodology. Facilities operated by public hospital districts share the methodology described below also, except for proportionate share payments described in Section XVII below, which apply only to them.

This SPA is submitted by the single state agency for Medicaid, the State of Washington Department of Social and Health Services ("department" below). The amendment is necessary to describe changes to the payment methodology adopted by the 2001 state legislature commencing July 1, 2001, and July 1, 2002.

Excluded here is the payment rate methodology for nursing facilities operated by the department's Division of Developmental Disabilities, which is described in Attachment 4.19-D, Part II.

Chapter 388-96 of the Washington Administrative Code (WAC), chapter 74.46 of the Revised Code of Washington (RCW), and any other state or federal laws or regulations, codified or uncodified, as may be applicable, are incorporated by reference in Attachment 4.19-D, Part I, as if fully set forth.

The methods and standards used to set payment rates are specified in Part I in a comprehensive manner only. For a more detailed account of the methodology for setting nursing facility payment rates for the three indicated classes of facilities, consult chapter 388-96 WAC and 74.46 RCW, as amended for July 1, 2001, and July 1, 2002, rate setting.

The methods and standards employed by the department to set rates comply with 42 CFR 447, Subpart C, as superseded by federal legislative changes in the Balanced Budget Act of 1997.

Section II. General Provisions:

Medicaid rates for nursing facility care in Washington continue to be facility-specific. Prior to rate setting, nursing facilities' costs and other reported data, such as resident days, are examined, to ensure accuracy and to determine costs allowable for rate setting. Washington continues to be a state utilizing facility-specific cost data, subject to applicable limits, combined with facility-specific and regularly-updated resident case mix data, to set rates.

A facility's Medicaid rate continues to represent a total of seven component rates: (1) direct care, (2) therapy care, (3) support services, (4) operations, (5) variable return, (6) property, and (7) financing allowance.

Medicaid rates are subject to a "budget dial", under which the department is required to reduce rates for all participating nursing facilities statewide by a uniform percentage, after notice and on a prospective basis only, if the statewide average facility total rate, weighted by Medicaid resident days, approaches an overall limit for a particular state fiscal year. For SFY 2002 (July 1, 2001, to June 30, 2002) the budget dial is $128.79 per resident day, and for SFY 2003 (July 1, 2002, to June 30, 2003) it is $134.45 per resident day. The budget dial supersedes all rate setting principles in chapters 74.46 RCW and 388-96 WAC.

The former split budget dial, having one weighted average limit for the non-capital components (direct care, therapy care, support services, operations and variable return) and another weighted average limit for the capital components (property and financing allowance) continued only through June 30, 2001. Effective July 1, 2001, one dial has been re-established for the total rate as indicated.

Direct care, therapy care, support services and operations component rates for July 1,

2001, through June 30, 2004, are rebased on examined, adjusted costs and resident days from 1999 cost reports. Percentages assigned to nursing facilities to help determine each facility's variable return component are be based on 1999 costs, and apply to the July 1, 2001, to June 30, 2004, period.

In contrast, property and financing allowance components continue to be rebased annually, utilizing each facility's cost report data for the calendar year ending six months prior to the commencement of the July 1 component rates.

Section III. Minimum Occupancy for Rate Setting and Fluctuations in Licensed Beds:

All component rates calculated and assigned to a facility require, directly or indirectly, use of the examined number of resident days at that facility for the applicable report period. Essentially, days are divided into allowable costs for that period, to obtain facility costs expressed as per resident day amounts.

For July 1, 2001, rate setting, resident days for all facilities in all component rates continue to be subject to a minimum occupancy of 85 percent of each facility's licensed beds, regardless of how many beds are set up or in use. That is, if resident days are below this minimum for the applicable cost report period, they are increased to an imputed occupancy of 85 percent for rate setting, which has the effect of reducing per resident day costs and component rates based on them.

If occupancy is above the minimum, the facility's actual occupancy is used. The purpose of minimum occupancy is to prevent inflated rates based on inefficient use of facility resources or failure of the facility to maintain a viable census.

Effective July 1, 2002, minimum occupancy for rate setting for all facilities will continue at 85 percent in direct care, therapy care, support services and variable return component rates. However, effective as of this date, except for facilities designated as essential community providers, minimum occupancy will be raised from 85 percent to 90 percent for calculation of operations, financing allowance and property component rates, and these components will be revised downward, if indicated, effective July 1, 2002, to reflect the higher minimum.

As noted, this increase in minimum occupancy for the affected components will not apply to essential community providers, who will continue to be subject only to an 85 percent

minimum occupancy for all components on and after July 1, 2002. An "essential community provider" is defined by a minimum driving time of forty minutes to the next nearest nursing facility.

Rates in all components for all facilities on and after July 1, 2001, continue to be subject to a downward revision, if indicated, to reflect a recalculation of minimum occupancy when a facility's licensed beds are increased (or "unbanked") by converted previously de-licensed beds back to licensed status under chapter 70.38 RCW.

However, effective July 1, 2001, for all facilities except essential community providers, component rates in direct care, therapy care, support services, and variable return only continue to be subject to an upward revision, if indicted, when a facility's licensed beds are reduced (or "banked") under chapter 70.38 RCW.

Effective July 1, 2001, for all facilities except essential community providers, operations, property, and financing allowance component rates are not subject to increase when licensed beds are reduced under chapter 70.38 RCW, on or after May 25, 2001.

Effective July 1, 2001, for essential community providers, rates in all components will continue to be subject to an increase, if indicated, in response to a reduction in licensed beds under chapter 70.38 RCW, regardless of when the reduction occurs.

If a facility's affected component rates are revised downward or upward, in response to an increase or reduction, respectively, in its licensed beds under chapter 70.38 RCW, any revision is accomplished by a recalculation of minimum occupancy. The department tests the facility's 1999 resident days or prior year resident days, as applicable, against the facility's new licensed bed capacity.

A per resident day cost adjustment is made, reversed or modified, as may be indicated, and any rate revision is made prospectively, effective as of the date licensed bed capacity is increased or reduced.

Section IV. Allowable Costs:

Allowable costs for rate setting, audit and settlement are documented costs, not expressly declared unallowable or otherwise limited under chapter 74.46 RCW or 388-96 WAC, that are necessary, ordinary and related to the care of nursing facility residents. To be

ordinary nursing facility expenses, costs must be of the nature and magnitude that prudent and cost-conscious management would pay. Effective July 1, 2001, facility costs of televisions in residents' rooms acquired on and after July 1, 2001, will be included in allowable costs.

Costs in excess of limits or in violation of any rate setting or payment principles contained in chapters 74.46 RCW or 388-96 WAC are expressly unallowable. These limits include, but are not limited to, minimum occupancy for rate setting and peer group median costs in affected cost areas and component rates.

Allowable cost limits and principles of rate setting include, in the broad sense, not only those contained in chapters 74.46 RCW and 388-96 WAC, but also those contained an all applicable state and federal laws and regulations, whether codified or uncodified, as may be pertinent to all or part of the July 1, 2001, through June 30, 2004, rate period, as may be interpreted by courts of competent jurisdiction.

The Medicaid payment rate system for the State of Washington does not guarantee that all costs relating to the care of a nursing facility's Medicaid residents and allowable under the payment system rules will be fully covered or reimbursed in any payment period. The primary goal of the system is to pay for nursing care rendered to Medicaid-eligible residents in accordance with state and federal laws, not to reimburse costs, however defined, of a provider.

Section V. Adjustments to Payment Rates for Economic Trends and Conditions:

Effective July 1, 2001, all facilities receive a 2.1 percent upward adjustment for economic trends and conditions to their therapy care, support services and operations component rates.

Effective July 1, 2002, all facilities receive a 2.3 percent upward adjustment for economic trends and conditions to their therapy care, support services and operations component rates.

Effective July 1, 2001, all facilities having their direct care component rates established on case mix principles promulgated in law receive a 2.1 percent upward adjustment for economic trends and conditions to their direct care component rates. Facilities

continuing to receive a "hold harmless" direct care component rate as of July 1, 2001, receive no upward adjustment for economic trends and conditions to their direct care component rates.

Effective July 1, 2002, all facilities having their direct care component rates established on case mix principles promulgated in law and regulation, receive a 2.3 percent upward adjustment for economic trends and conditions to their direct care component rates. Any facilities continuing to receive a "hold harmless" direct care component rate as of July 1, 2002, receive no upward adjustment for economic trends and conditions to their direct care component rates; however, the hold harmless provision is terminated effective July 1, 2002, also, so unless this scheduled change to the methodology is eliminated for some facilities, all facilities should receive the 2.3 upward adjustment for economic trends and conditions effective July 1, 2002.

Section VI. Direct Care Component Rate:

This component rate, which averages approximately 55.5% of each participating facility's total Medicaid rate, corresponds to one resident day of care for nursing services, including supplies, excluding therapy care services and supplies.

Effective July 1, 2001, direct care component rates are cost-rebased using adjusted direct care costs taken from 1999 cost reports, and applying case mix principles; however, the option to receive a "hold harmless" direct care component rate for qualifying nursing facilities will continue for the July 1, 2001, through June 30, 2002, prospective rate period. The direct care component rates of some facilities will be subject to upward adjustments for economic trends, as specified above, effective July 1, 2001, and July 1, 2002. (See Section V, Adjustments to Rates for Economic Trends and Conditions, above.)

Direct care components rates, as all component rates, are subject to potential prospective reduction under the budget dial described above.

The "hold harmless" direct care provision dates back to October 1, 1998, under which a facility's direct care component rate cannot fall below the facility's "nursing services" component rate in effect on September 30, 1998, subject to adjustment to eliminate therapy services and supplies.

The hold harmless option in direct care will be discontinued for all facilities effective July 1, 2002. Also, effective July 1, 2001, any facility having its direct care component rate established on case mix principles promulgated in law and regulation, shall be ineligible to return to a hold harmless direct care component rate.

For state fiscal year (SFY) 2002 (July 1, 2001, to June 30, 2002), 45 cents per resident day is added to the direct care component rates of all participating facilities, after cost-rebasing, updates for changes in case mix, and adjustments for economic trends and conditions, if any. The added money is intended for use by facilities to increase compensation for low wage earners in each nursing facility, subject to use monitoring by the department. For SFY 2003 (July 1, 2002, to June 30, 2003), to help preserve these funds earmarked for low wage workers, the department shall increase by .6 percent the median cost per case mix unit for all three direct care peer groups, and direct care component rates for all facilities will reflect this increase for SFY 2003.

Effective July 1, 2002, there will be a one-time increase in the median cost per case mix unit for rate setting of 2.64 percent for all peer groups, in order to ease the transition to case mix only direct care rates as of this date.

In setting July 1, 2001, direct care component rates, adjusted, allowable direct care costs are taken from each facility's 1999 cost report and, subject to all limitations, are divided by adjusted, total resident days for each facility from the same report, increased, if necessary to the imputed minimum occupancy specified above, to derive an allowable cost per resident day for each facility.

In applying case mix principles for direct care rate setting, data is taken from facility-completed, mandatory assessments of individual residents, and using a software program that groups residents by care needs, the department determines for each facility both a facility average case mix index (for all the facility's residents) and a Medicaid average case mix index (for Medicaid residents only). A case mix index is a number indicating intensity of need for services by a resident population, or group within a population.

Each facility's allowable direct care cost per resident day is divided by the facility's average case mix index to derive the facility's allowable direct care cost per case mix unit.

For July 1, 2001, rate setting, the department will continue to array facilities' 1999 direct care costs per case mix unit to determine median costs per case mix unit for setting rates

in direct care.

Effective July 1, 2001, in setting direct care component rates, the department is required to array direct care costs per case mix unit separately for three groups of nursing facilities, also known as peer groups: (1) those located in a high labor-cost counties; (2) those located in urban counties, which are not high labor cost counties; and (3) those located in nonurban counties.

A "high labor cost county" is "an urban county in which the median allowable facility cost per case mix unit is more than ten percent higher than the median allowable facility cost per case mix unit among all other urban counties, excluding that county". An "urban county" is "a county which is located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government". A "nonurban county" is "a county which is not located in a metropolitan statistical area as determined and defined by the United States office of management and budget or other appropriate agency or office of the federal government".

Currently, the only high labor cost county in the state is King County, which means for July 1, 2001, through June 30, 2004 direct care component rates, direct care cost per case mix unit medians are calculated for: (1) Medicaid nursing facilities in King County; (2) Medicaid nursing facilities in all urban counties, excluding King County; and (3) Medicaid nursing facilities in all nonurban counties.

Continuing for July 1, 2001, rate setting, and all future rate setting, a facility's direct care cost per case mix unit is adjusted, if necessary, to bring it up to a floor of ninety percent, or down to a ceiling of one hundred ten percent, of the facility's peer group median cost per case mix unit (high labor cost, urban excluding high labor cost, or nonurban).

Effective July 1, 2001, subject to applicable adjustments for economic trends and conditions, possible application of the budget dial, and the direct care hold harmless provision through June 30, 2002, a facility's direct care component rate is equal to its allowable direct care cost per case mix unit from its 1999 cost report, multiplied by its Medicaid average case mix index from the applicable quarter.

Direct care component rates are updated effective the first day of each calendar year quarter (January 1, April 1, July 1, and October 1) to reflect changes in a facility's case mix. The resident assessment data used for each update is taken from the calendar

quarter commencing six months and ending three months prior to the effective date of each quarterly update.

Section VII. Therapy Care Component Rate:

This component payment rate corresponds to average one-on-one care from qualified therapists delivered to a Medicaid resident during one day, and to average therapy consultation from qualified consultants delivered to a resident during one day. Four types of therapy are recognized for rate setting: speech, physical, occupational, and other. Two general service categories are recognized for each: one-on-one therapy and therapy consulting.

To set therapy care component rates effective July 1, 2001, the department takes from 1999 cost reports direct one-on-one therapy charges for all residents by payer, including costs of supplies, and total units or modules of therapy care, for all residents from the report period by type of therapy provided. The department also takes from 1999 reports therapy consulting expenses for all residents by type of therapy provided.

The department determines the total one-on-one cost for each type of therapy care at each participating nursing facility, and divides by the facility's total units of therapy for each therapy type, to derive the per unit one-on-one cost for each type. A unit or module of therapy care is defined as fifteen minutes of one-on-one therapy.

The department determines total therapy consulting for each type of therapy at each nursing facility, and divides by the facility's resident days, increased if necessary to the applicable minimum occupancy, to derive per resident day consulting cost for each type of therapy.

The department ranks from lowest to highest per unit one-on-one therapy costs for each of the four types, both for urban and nonurban facilities. The department also ranks from lowest to highest per resident day therapy consulting costs for each of the four types of therapy, both for urban and nonurban facilities.

This constitutes sixteen separate arrays of therapy costs, which are used to determine eight median therapy costs for all facilities in each peer group (urban and nonurban). Four are one-on-one unit of therapy cost medians, and four are consulting resident day cost medians.

Sixteen cost limits are established, including both peer groups. The limits are one hundred ten percent of the median costs per unit of one-on-one therapy for the four types, and one hundred ten percent of the median costs per resident day for therapy consulting for the four types.

A facility's allowable one-on-one cost for rate setting, for each type of therapy care, is the lower of the facility's actual cost per unit or one hundred ten percent of the unit median cost for its peer group.

A facility's allowable consulting cost for rate setting, for each type of therapy care, is the lower of the facility's actual cost per resident day or one hundred ten percent of the resident day median cost for its peer group.

Each facility's allowable cost per case mix unit in each of the four therapy types is then multiplied by the units provided by the facility in 1999 by type. The result is multiplied by the Medicaid percentage of charges for each category, and divided by adjusted Medicaid resident days from the report period, to derive the Medicaid resident day allowable one-on-one cost for each therapy type.

The facility's allowable Medicaid resident day one-on-one cost and its allowable resident day consulting cost are each multiplied by the facility's total adjusted 1999 resident days to calculate its total allowable one-on-one therapy expense and total allowable consulting therapy expense. These products are totaled for each type to derive each facility's total allowable cost for each therapy type.

The total allowable cost for each therapy type for each participating nursing facility is then combined and this total is divided by the facility's total adjusted resident days, or days increased, if needed, to the applicable minimum occupancy for rate setting, to derive its therapy care component rate.

Section VIII. Support Services Component Rate:

This component rate corresponds to one resident day of food, food preparation, other dietary services, housekeeping and laundry services.

Effective July 1, 2001, a nursing facility's support services component rate is based on its 1999 cost report data, subject to the budget dial and applicable adjustments for economic

ranking exercise is done, without regard to urban or nonurban peer groups, and the ranked costs are not reduced by the peer group limits based on peer group median costs. The array is then divided into four quartiles, each containing, as nearly as possible, the same number of facilities.

The department then assigns a percentage to each facility, depending on what quartile it belongs to, as follows: 1 percent to those in the highest quartile, 2 percent to those in the next highest quartile, 3 percent to those in the next lowest quartile, and 4 percent to those in the lowest quartile.

The percentages calculated from 1999 costs shall remain in effect from July 1, 2001, until June 30, 2004. Facilities will not be ranked again and no new percentages will be determined after being done initially for July 1, 2001, rate setting. If a facility migrates from one quartile to another resulting from in increase or decrease in its 1999 allowable costs after the percentages are initially calculated and assigned, its percentage will be changed to reflect its new quartile, and its variable return component rate will be revised, effective July 1, 2001.

Once assigned, the applicable variable return percentage is multiplied by each facility's combined per resident day component rates in direct care, therapy care, support services, and operations to derive its variable return component rate; however, allowable direct care spending per resident day during the preceding calendar report year will be substituted for a facility's direct care component rate in calculating its variable return, if spending was lower than its current direct care component rate. The variable return component rate is adjusted each time one or more of these component rates is changed, whether to reflect an adjustment for economic trends and conditions, a quarterly update to reflect a change in case mix, or for any other reason.

Section XI. Property Component Rate:

This component corresponds to an allowance for depreciation of real property improvements, equipment and personal property associated with the provision of resident care at a participating nursing facility.

Effective July 1, 2001, the property component rate continues to be cost-rebased annually using cost report depreciation data from the calendar year ending six months prior to the commencement of each July 1 rate. For example, the 2000 cost report is used for July 1,

2001, rate setting, and the 2001 cost report is used for July 1, 2002, etc. Allowable depreciation is divided by the actual, adjusted resident days from the applicable cost report period, increased, if needed, to imputed resident days at the applicable minimum occupancy for rate setting.

The property rate is subject to prospective revision to reflect the cost of capitalized additions and replacements. Effective July 1, 2001, to have additional assets included for rate setting the contractor must obtain from the department a certificate of capital authorization for future capitalized additions and replacements, which are available on a first-come, first served basis. However, the department is authorized to consider untimely requests if the improvement project is in response to an emergency situation.

Authorizations cannot exceed the following legislatively-imposed limits -- $10 million for state fiscal year (SFY) 2003, $27 million for SFY 2004, and $27 million for SFY 2005.

For assets that were acquired after January 1, 1980, the depreciation base of the assets used for rate setting cannot exceed the net book value which did exist or would have existed had the previous contract with the department continued, unless the assets were acquired after January 1, 1980, for the first time since that date, and before July 18, 1984.

The depreciation base that will be used for first-time sales after January 1, 1980, but occurring pursuant to a written and enforceable purchase and sale agreement in existence prior to July 18, 1984, and documented and submitted to the department prior to January 1, 1988, will be that of the first owner subsequent to January 1, 1980.

Subsequent sales during the period defined above, and any subsequent sale of any asset, whether depreciable or not depreciable, on or after July 18, 1984, are ignored for payment purposes.

Section XII. Financing Allowance Component Rate:

The financing allowance rate is paid in lieu of payment determined by actual lease and interest expense, except for the cost of leasing office equipment, which is factored into the operations component rate, subject to all system limits and principles.

Effective July 1, 2001, a facility's financing allowance component rate continues to be

reset annually based on a facility's cost report data from the calendar year ending six months prior to the start of each July 1 rate. For example, July 1, 2001, financing allowance component rates are based on 1999 cost report data, and July 1, 2002, is based on 2000 data, etc.

A facility's net invested funds, for rate setting purposes, consists of the recognizable value of allowable tangible fixed assets and the allowable cost of land employed by the facility to provide nursing facility services. Valuation of allowable land and depreciable assets will be subject to the same purchase date limitations affecting depreciable assets for calculation of a facility's property component rate described in Section X. In calculating net invested funds, facilities continue to be subject to the cost basis of the last owner of record prior to July 18, 1984, for assets existing prior to that date.

For assets acquired on or after May 17, 1999, the return percentage factor will be 8.5 percent, and for those acquired prior to this date, the percentage factor will continue to be 10 percent. However, the factor will be 10 percent for real property assets acquired on or after May 17, 1999, if they received a certificate of need approval or an exemption from certificate of need, or if working drawings relating to the assets were submitted to the State of Washington Department of Health for certificate of need approval on or after May 17, 1999.

The financing allowance component rate is computed by multiplying each facility's allowable net invested funds, taken from its cost report for the preceding calendar year, by 10 percent in whole or in part, and/or by 8.5 percent in whole or in part, as applicable. The products are then added, if needed, and divided by the greater of adjusted resident days from the same report period, increased, if needed, to imputed days at the applicable minimum occupancy for rate setting.

Section XIII. Settlement:

In a process called "settlement", direct care, therapy care, and support services component rate payments are compared to each participating nursing facility's expenditures in these categories each report period. The facility must return to the department all unspent rate payments in these three categories exceeding 1 percent of each average component rate, weighted by Medicaid resident days, for the report period. The purpose of settlement is to provide licensees of Medicaid nursing facilities additional incentive to make expenditures necessary for the care and well being of residents.

This recovery process does not exist for payments in excess of costs, if any, in the operations, variable return, property and financing allowance component rates. However, assets constituting net invested funds are subject to audit and a facility's financing allowance component rate is subject to adjustment at settlement, up or down, to reflect actual, documented net invested funds relating to resident care. If the financing allowance component rate is increased or reduced to reflect a change in net invested funds, the financing allowance underpayment or overpayment to the facility for the settlement period will be reflected in the settlement and amount due the contractor or department.

Normally settlement covers a calendar year corresponding to a calendar year report period, but a settlement will only cover a partial-year report period for facilities changing ownership during the year. The rate a provider is left with after the process of settlement at the lower of cost or rate in the affected cost areas is called the "settlement rate" and it represents final compensation for Medicaid nursing care services for the settlement period.

The rule which allows facilities to keep unspent payments in direct care, therapy care and support services up to 1 percent of each of these component rates, does not apply to facilities that provided substandard quality of care, or which were not in substantial compliance with state and federal care standards, during the settlement period, as these concepts are defined in federal survey regulations. Such facilities must return all unspent direct care, therapy care and support services rate payments, without exception, they received during the settlement period.

In comparing expenditures to component rate payments in direct care, therapy care, and support services for the purpose of calculating a facility's settlement rate and effecting recovery, some shifting of excess rate payments (if any) to other cost areas is allowed to cover in whole or in part costs exceeding component rates in those other areas (if any).

Effective July 1, 2001, savings in support services may be shifted to cover a deficit in direct care or therapy care, but not more than 20 percent of the total support services rate payment for the settlement period may be shifted out. Shifting of savings in direct care to therapy care, and from therapy care to direct care, to cover any deficit is allowed without a percentage of component rate limitation.

Section XIV. Adjustments to Prospective Rates other than for Economic Trends and Conditions, Changes in Case Mix, Fluctuation in Licensed Beds, or One-Time Specific Authorizations:

The department may grant prospective rate adjustment to fund new requirements imposed by the federal government or by the department, if the department determines a rate increase is necessary in order to implement the new requirement.

Rates may be revised prospectively to fund capitalized facility additions and replacements meeting all applicable conditions, such as certificate of need or exemption from certificate of need, and a certificate of capital authorization from the department, if required for the project.

Rates may be adjusted prospectively and retrospectively to correct errors or omissions on the part of the department or the facility, or to implement the final result of a provider appeal if needed, or to fund the cost of placing a nursing facility in receivership or to aid the receiver in correcting deficiencies.

Rates may be revised to reflect an increase in real property taxes resulting from a facility building construction, expansion, renovation or replacement project, but only up to the median cost limit in the affected component, the operations component rate. Also, to qualify, the project must require the purchase of additional land, must have been completed on or after July 1, 1997, and the rate increase cannot commence prior to the effective date of the tax increase.

Section XV. Rates for Swing Bed Hospitals:

Rates for swing bed hospitals providing nursing facility care to Medicaid eligible residents continue to be set for each SFY (July 1 through June 30) at the approximate, weighted statewide average total paid to Medicaid nursing facilities during the preceding SFY. So the Medicaid swing bed rate effective July 1, 2001, is derived from the average nursing facility Medicaid rate for SFY 2000.

The average rate comprising the swing bed rate for July 1, 2001, is computed by first multiplying each nursing facility's approximate total rate on July 1 of the preceding fiscal year (July 1, 2000) by the facility's approximate number of Medicaid resident days for the month of July during the preceding SFY (July 2000), which yields an approximate total

Medicaid payment for each facility for that month.

Total payments to all Medicaid facilities for July of the preceding SFY are added which yields the approximate total payment to all facilities for that month, and then the total is divided by statewide Medicaid resident days for the same month to derive a weighted average for all facilities.

The average for July 2000 was $122.97 per resident day, which comprises the swing bed rate for the July 1, 2000 to June 30, 2002 rate period. The same methodology is followed annually to reset the swing bed rate, effective July 1 of each year.

Section XVI. 1997 Balanced Budget Act, Section 4711 -- Public Process for Changes to Nursing Facility Medicaid Payment Rates:

For all material changes to the methodology for determining nursing facility Medicaid payment rates occurring on or after October 1, 1997, requiring a state plan amendment, the state's Medicaid agency, the Department of Social and Health Services, shall follow the following public process:

(1) The proposed estimated payment rates, the proposed new methodologies for determining payment rates, and the underlying justifications shall be published. Publication shall be: (a) in the Washington State Register; or (b) in The Seattle Times and in The Spokesman Review newspapers.

(2) The department shall maintain and update as needed a mailing list of all individuals and organizations wishing to receive notice of changes to the nursing facility Medicaid payment rate methodology, and all materials submitted for publication shall be sent postage prepaid by regular mail to such individuals and organizations as well.

(3) Nursing facility providers, their associations, nursing facility Medicaid beneficiaries, representatives, and other concerned members of the public shall be given a reasonable opportunity to review and comment on the proposed estimated rates, methodologies and justifications. The period allowed for review and comment shall not be less than fourteen (14) calendar days after the date of the Washington State Register containing the published material or the date the published material has appeared in both The Seattle Times and The Spokesman Review.

(4) After receiving and considering all comments, if the department decides to move ahead with a change or changes to its nursing facility payment rate methodologies, it shall adopt needed further changes in response to comments, if any, and shall publish the final estimated rates, final rate determination methodologies and justifications. Publication shall be: (a) in the Washington State Register; or (b) in The Seattle Times and The Spokesman Review newspapers. Unless an earlier effective date is required by state or federal law, implementation of final changes in methodologies and commencement of the new rates shall not occur until final publication in the Register has occurred or publication in both designated newspapers has occurred. The department shall not be authorized to delay implementation of changes, or to alter, ignore or violate requirements of state or federal laws in response to public process comments.

Section XVII. Proportionate Share Payments for Nursing Facilities Operated by Public Hospital Districts:

A proportionate share pool is created each state fiscal year for supplemental payments to eligible providers of Medicaid nursing facility services. Eligible providers are hospital districts that operate nursing facilities.

Funds retained by the districts shall be used to improve access to health care in rural areas at nursing facilities. Federal matching funds resulting from the supplemental payments to the districts shall be used for important state health care needs.

The supplemental payments made to public hospital districts are subject to prior federal approval for obtaining federal matching funds for the supplemental payments to the districts, legislative appropriations for the supplemental payments, a contractual commitment by each hospital district to return a minimum of 82 percent by intergovernmental transfer to the state treasurer for deposit in the health services account, and a contractual commitment by the districts to not allow expenditures covered by the supplemental payments to be included in costs used to set Medicaid nursing facility payment rates.

The supplemental payments shall not be subject to rules governing settlement (payment at the lower of cost or rate), or to rules governing rates contained in chapter 74.46 RCW and chapter 388-96 WAC. However, they are subject to the federal Medicare upper limit for nursing facility payments. The Medicare upper limit analysis shall be performed prior to making the supplemental payments.

Section XIX

The State has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.